

Application for License to
Operate a Long-term Care Facility

For Office Use Only
Received 10-26-11
Amount 1320/1400

mailed to Nicole
Jobe 12/15/11
ch#1240

I. IDENTIFICATION

Name Arbor Place of Clinton
Address 106 Padgett Drive
City/County/Zip Clinton, Hickman County, Kentucky 42031
Telephone number (270) 653-5558
Administrator Trella Wilson
Date facility operation began at current address 4/16/2003
Date facility began operation under current owner 4/16/2003

II. TYPE BEDS	No. beds licensed	No. beds requested
Skilled	<u>88</u>	<u>88</u>
Nursing Home		
Nursing Facility	<u>88</u>	<u>88</u>
Intermediate Care		
ICF/MR		
Personal Care	<u>10</u>	<u>10</u>

II. CONTROL (check one in each column)

	Profit Nonprofit	Individual Partnership Corporation
State		
County		
City		
Private		

II. OWNERSHIP

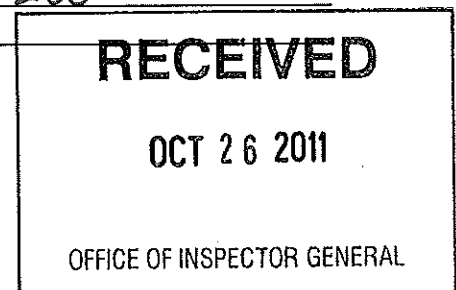
Name and address of individual owner, partners or corporation. If partnership, list partners.

Benchmark Healthcare Management
1795 Clarkson Road, Suite 200
Chesterfield, MO 63017

Send Validation letter to:
* Nicole Jobe

NJOBE@BENCHMARKHEALTH.NET

(OVER)



12/31
R.B.

If facility owned or leased by a corporation, complete the following:

Name of corporation Belmont Gardens, Inc.
Address of corporation 106 Padgett Drive, Clinton, KY 42031
President or Chairman John M. Sells
Vice President _____
Secretary Arthur Catrino
Treasurer _____

Attach a separate sheet listing the names and addresses of each person having at least a twenty-five (25) percent ownership interest in the facility.

If owned by a corporation, attach a separate sheet listing the names and addresses of each officer or director of the corporation.

If owned by a partnership, attach a separate sheet listing the names and addresses of each partner.

Name and address of parent corporation and/or management company, if applicable.

Parent
B H H, Inc.
1795 Clarkson Road, Ste. 200
Chesterfield, MO 63017

Management Company
Benchmark Healthcare Management
1795 Clarkson Road, Ste. 200
Chesterfield, MO 63017

I understand that any change in the application that affects my licensure status will be reported to the Office of Inspector General and a new application will be completed at that time. I agree that this facility and all aspects of its operation shall be open at all times to inspection and surveillance by all state agency licensure personnel. I certify that the information given in completing this application is accurate to the best of my knowledge and recognize that falsification of this application can result in denial or revocation of licensure.



Signature of authorized representative

President

Title

10/22/11

Date

Return Application and fee to:

Office of Inspector General
275 East Main Street, 5E-A
Frankfort, Kentucky 40621

OIG 5
(10/2002)